211 CMR 65.00: LONG-TERM CARE INSURANCE

Section

65.01: Purpose

The purpose of 211 CMR 65.00 is to provide for full and fair disclosure of the provisions of long-term care insurance policies offered in Massachusetts and to promote the public interest by protecting applicants for long-term care insurance from unfair or deceptive sales and enrollment practices. 211 CMR 65.00 establishes minimum standards for individual long-term care insurance policies and minimum standards for disclosure, marketing and agent training for both individual long-term care insurance policies and group long-term care insurance policies that are not employment-based. 211 CMR 65.00 is intended to facilitate public understanding and comparison of long-term care policies, and to encourage flexibility and responsible innovation in the development of long-term care insurance.

65.02: Applicability

211 CMR 65.00, unless otherwise stated herein, applies to long-term care insurance policies or certificates offered in Massachusetts after February 25, 2005. The requirements contained in 211 CMR 65.00 are in addition to any other applicable statutory provisions or lawful regulations, including 211 CMR 40.00 and 211 CMR 42.00 where applicable. They do not in any way excuse any material noncompliance on the part of any agent or carrier marketing long- term care insurance regarding the provisions of any other law or statute. Unless otherwise stated, 211 CMR 65.00 does not apply to an employment-based group policy.

65.03: Authority

211 CMR 65.00 is issued under the authority of M.G.L. c. 118E, c. 175 § 108, and c. 176D.

65.04: Definitions

Activities of Daily Living (ADLs) means eating, toileting, transferring, bathing, dressing, and continence.

Agent means either:

(a) a person licensed as an insurance producer under M.G.L. c. 175, § 162I; or

(b) any other person legally authorized to represent a carrier in the marketing of long-term care insurance.

Alternate care benefits means benefits for services or other items not specified in the long-term care insurance policy, but to be covered as agreed to by the carrier, the insured, and the insured's caregiver. This includes, but is not limited to, payment for home modifications that allow the insured to continue living at home or a non-institutionalized setting and coverage of long-term care services that might not exist on the policy issue date.

Care management means those procedures employed by a carrier to approve covered services and to determine the appropriate level of care.

Carrier means a commercial insurance company licensed to issue accident and sickness policies under M.G.L. c.175 or a fraternal benefit society licensed under M.G.L. c.176.

Cold-lead advertising means making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that one of the purposes of the method of marketing is the solicitation of insurance and that contact will be made by a carrier or its agent.

Commissioner means the commissioner of insurance or his/her designee.

Convertible means a policy feature that gives the insured the right to switch to another policy offered or sponsored by the carrier.

Daily maximum benefit means the maximum daily amount that the long-term care insurance policy pays for specific services.

Deductible means the dollar amount of covered services that are to be paid solely by the insured before the long-term care insurance policy begins to pay benefits.

Division of Medical Assistance means the state agency responsible for administering programs of medical assistance in Massachusetts pursuant to M.G.L. c. 118E.

Elimination period means the number of days during which covered services must be received by an insured before the long-term care insurance policy begins to pay benefits.

Employment-based group policy means a certificate issued to an insured who is enrolled in a group policy issued to one or more employers or labor organizations, or to the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Federally qualified means a policy that meets standards set forth in the federal Internal Revenue Code and related federal regulations in order to qualify for special tax treatment.

Group policy means the certificate issued to an insured who is enrolled through a group trust or association to which the carrier has issued a long-term care insurance policy. For the purposes of 211 CMR 65.00, this does not include employment-based group policies.

Guaranteed renewable means a policy feature that guarantees the insured's right to continue the policy in force by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, and cannot make any unilateral change in any provision of a guaranteed renewable policy without the agreement of the insured, but subject to the approval of the commissioner, a carrier may revise premium rates for guaranteed renewable policies on a class basis.

High-pressure tactics means employing any method of marketing that has the effect of or tends to induce or recommend the purchase of any insurance policy through force, fright, threat (whether explicit or implied) or undue pressure.

Home Health Care means nursing, home health aide, rehabilitative therapy, and nutrition counseling services.

Individual policy means a policy issued by a carrier directly to an insured.

Insured means the named policyholder or certificateholder under a long-term care insurance policy.

Lifetime maximum benefit period means the maximum number of days of benefits, as chosen by the insured, which the carrier will pay for covered benefits after the satisfaction of any elimination period or deductible.

Lifetime maximum dollar amount means the maximum dollar amount, as chosen by the insured, which the carrier will pay for covered benefits after the satisfaction of any elimination period or deductible.

MassHealth (Medicaid) means the program of medical assistance administered by the Massachusetts Division of Medical Assistance under Title XIX of the federal Social Security Act, 42 USCS § 1396 et seq., and M.G.L. c. 118E.

Medical necessity means:

(a) in accordance with accepted standards of medical practice for the diagnosis and treatment of a condition;

(b) delivered, when possible, in the least intensive setting required by the insured's condition; and

(c) not solely for the convenience of the insured, the insured's family or the insured's health care provider.

Medicare means the federal health insurance program under Title XVIII of the federal Social Security Act, 42 USCS § 1395 et seq., as amended.

Mental or nervous condition means a condition as described in the standard nomenclature of the American Psychiatric Association.

Noncancelable means the policy feature that guarantees the insured's right to continue the policy in force at the same premium level by the timely payment of premiums. A carrier cannot cancel, cannot decline to renew, cannot make any unilateral change in any provision of coverage, and cannot revise premium rates for a noncancelable policy without the agreement of the insured.

Nonforfeiture benefit means a benefit to the insured in the event that the long-term care insurance policy lapses due to nonpayment of premium. Nonforfeiture benefits include, but are not limited to, return of premium and any partial paid-up benefits.

Policy means an individual long-term care insurance policy or a certificate of a group policy that is not employment-based, as well as the policy application, riders, amendments or other provisions that are attached to the policy to identify the contractual provisions of the insured's coverage.

Pre-existing condition means a medical condition for which an insured received diagnosis or treatment during the 24-month period prior to the effective date of coverage.

Twisting means knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or carriers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any policy or to take out a policy with another carrier.

65.05: Minimum Standards for Individual Policies

(1) Benefit Eligibility Standards.

(a) Benefit Triggers.

1. Individual policies that are not intended to be federally qualified may not include benefit eligibility standards that are more stringent than a requirement that the insured be unable to perform at least two Activities of Daily Living due to a loss of functional capacity or severe cognitive impairment.

2. Individual policies that are intended to be federally qualified are required to meet the standards set forth in the federal Internal Revenue Code and related federal regulations.

(b) Prior Treatment Requirements. No individual policy may condition long-term care benefits on the insured's prior hospitalization or prior receipt of services from any long-term care provider.

(c) Medicare Eligibility. No individual policy may restrict or deny benefits because the insured is not eligible for Medicare.

(d) Improvement Requirement. No individual policy may condition receipt of covered benefits on a requirement that the insured be making a "steady improvement", have "recuperative potential" or have "returned to pre-morbid condition" or words of similar import.

(e) Medical Necessity. No individual policy may condition receipt of any services, except medical servicesprovided by licensed medical professionals, on any standard of medical necessity. Any carrier using a medical necessity standard shall disclose that standard within the policy.

(f) Care Management. A carrier may establish a care management system to manage the benefits provided under the individual policy, and plan benefits may be disallowed if specific care management standards and procedures are not met. A carrier that intends to use a care management system must:

1. establish a needs assessment tool which measures functional ability,

2. file with the commissioner a description of its care management policy and procedures, as well as the mechanism by which the insured may appeal a care management decision, and file any and all updates to the management policy and procedures with the commissioner prior to implementation

3. specify the care management procedures within the policy, as well as the way to appeal whenever benefits are disallowed for failure to meet care management standards, and notify the insured about any changes to care management procedures included in the policy prior to implementation, and

4. disclose applicable care management standards to insureds upon request.

(2) Benefit Requirements.

(a) Elimination Periods and Deductibles.

1. Individual policies may not include elimination periods of greater than 365 days, whether services are received within or away from the home.

2. At a minimum, carriers shall count each day that the insured receives any service that would be applied against the lifetime maximum benefit amount or maximum benefit period toward the satisfaction of an individual policy's elimination period. Individual policies may not require that elimination periods be satisfied within a specified period of time or that days be consecutive.

3. Individual policies may not apply more than one elimination period unless the insured has received no benefits for at least 180 consecutive days.

4. Individual policies may offer deductibles in lieu of elimination periods, but not both.

(b) Individual Policy Benefits.

1. Daily maximum benefit amounts for specific services must be clearly defined within the policy provisions. The daily maximum benefit may be limited by the carrier to the usual and customary cost of the service. If the service costs more than the maximum daily benefit and there is no law to the contrary, the insured is responsible for the amount over and above the daily maximum benefit.

2. Lifetime maximum benefit periods may not cover fewer than 730 days beyond the policy's elimination period.

3. Individual policies may include a lifetime maximum benefit amount in lieu of the lifetime maximum benefit period, provided that the lifetime maximum benefit amount may not be less than the product of 730 multiplied by the highest daily maximum benefit amount covered in the policy.

(c) Home Health Care Benefits in Long-Term Care Insurance Policies.

1. An individual policy shall not, if it provides benefits for home health care services, limit or exclude benefits:

a. by requiring that the insured or claimant would need care in a skilled nursing facility if home health care were not provided;

b. by requiring that the insured or claimant first or simultaneously received nursing or therapeutic services, or both, in a hospital or institutional setting before home health care services are covered;

c. by limiting eligible services to services provided by registered nurses or licensed practical nurses;

d. by requiring that the provisions of home health care services be at a level of certification or licensure greater than that required by the eligible services;

e. by requiring that the insured or claimant have an acute condition before home health care services are covered; or

f. by limiting benefits to services provided by Medicare-certified agencies or providers.

2. A long-term care insurance policy or certificate, if it provides for home health care services, shall provide total home health coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time the covered home health services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

3. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(d) Minimum Benefits. Individual policies may not include any policy benefits that are so limited in scope that they are not likely to be of any substantial economic value to the insured.

(e) Alternate Care Benefits. Individual policies must include a provision that enables the insured to use policy benefits after satisfying policy benefit triggers, elimination periods and deductibles to cover long-term care treatments or expenses not specifically identified in the policy's described benefits. The alternate care benefits must be made available to the insured subject to the agreement of the carrier, the insured and the insured's health care practitioner.

(3) Limitations and Exclusions.

(a) Pre-existing condition limitations.

1. Pre-existing condition limitations must be identified on the front of the policy and the outline of coverage.

2. Pre-existing condition limitations may not apply for more than a six-month period from the effective date of the policy.

(b) No individual policy may exclude otherwise eligible persons from policy benefits due to the presence or history of mental or nervous conditions, Alzheimer's disease, alcoholism, or other chemical dependency.

(c) No individual policy may exclude otherwise eligible policy benefits because those benefits are also payable by a non-Medicare government agency or because the covered services are being received in a governmental facility.

(d) Other limitations. Individual policies may include other limitations or conditions subject to the approval of the commissioner, provided that they are clearly identified in a separate section of the policy. Such limitations may include, but are not limited to, illnesses, treatments or conditions arising out of the following circumstances:

1. war or act of war (whether declared or undeclared);

2. participation in a felony, riot or insurrection;

3. service in the armed forces or units auxiliary thereto;

4. attempted suicide or intentionally self-inflicted injury;

5. services provided for alcohol or drug detoxification;

6. aviation (this exclusion applies only to non-fare paying passengers);

7. services for which benefits are payable under Medicare, any state or federal workers' compensation program, employer's liability or occupational disease law, or any motor vehicle no-fault law;

8. services provided by members of the insured's immediate family; or

9. services for which no amount is normally charged in the absence of insurance.

(4) Continuation of Policy Benefits.

(a) Renewal.

1. Carriers may not refuse to renew any individual policy, except in cases when the carrier is under receivership, rehabilitation or liquidation proceedings pursuant to M.G.L. c. 175 or c. 176 § 33, administrative supervision pursuant to M.G.L. c. 175J or comparable statutory requirements of another jurisdiction. A carrier may discharge its obligation to renew existing individual policies only upon a finding that the carrier has obtained coverage for all existing insureds with equivalent benefits for value paid with another carrier.

2. All individual policies shall be guaranteed renewable or noncancelable.

(b) Extension of Benefits.

1. If an individual policy is terminated while an insured is confined to a nursing home, benefits shall continue until the earliest of the following occurs:

a. the insured is discharged from the nursing home,

b. the policy lifetime maximum benefit period has expired, or

c. the insured has exhausted the lifetime maximum benefit amount for nursing home services.

2. For the purposes of 211 CMR 65.05(4)(b), the insured shall be considered to be continuously confined to a nursing home while being transferred to another nursing home, receiving another level of nursing care in any nursing home or being transferred back to a nursing home from a temporary/acute hospitalization.

3. 211 CMR 65.05(4)(b) does not apply if coverage under the individual policy terminates because of failure of the policyholder to pay the premium within the time set forth in the policy.

65.06: Mandatory Benefit Offers for Individual Policies

(1) Inflation Adjustment Benefit.

(a) A carrier shall make available, at the time of application, an option to increase benefits in order to adjust for or mitigate against future inflation. The applicant must be informed regarding the cost of this benefit.

(b) The initial option to purchase an inflation adjustment benefit must be offered to every applicant without additional underwriting.

(c) The carrier must require the applicant to specifically reject this benefit on the application if he/she chooses not to include this benefit in the individual policy.

(2) Nonforfeiture Benefit.

(a) A carrier shall make available, at the time of application, an option to purchase a nonforfeiture benefit. The applicant must be informed regarding the cost of this benefit.

(b) The initial option to purchase a nonforfeiture benefit must be offered to every applicant without additional underwriting.

(c) The carrier must require the applicant to specifically reject this benefit on the application if he/she chooses not to include this benefit in the individual policy.

(3) Home Health Care Benefit.

(a) A carrier shall make available, at the time of application, at least one policy covering home health care that satisfies 211 CMR 65.05(2)(c).

(b) A carrier may satisfy this requirement through the offer of an affiliated or nonaffiliated carrier's product(s), as long as the arrangement is subject to a written contract filed with and approved by the commissioner.

(4) Long-Term Care Insurance Benefits Qualifying the Insured for Exemptions from Certain Massachusetts MassHealth (Medicaid) Provisions.

(a) A carrier shall make available, at the time of application at least one policy that satisfies the requirements of 130 CMR 515.014.

(b) A carrier may satisfy this requirement through the offer of an affiliated or nonaffiliated carrier's product(s), as long as the arrangement is subject to a written contract filed with and approved by the commissioner.

65.07: Form and Rate Filing Procedures for Individual Policies

(1) Carriers shall file all individual policy forms, including applications, disclosure statements and replacement forms, and associated rates pursuant to the provisions of 211 CMR 42.06.

(2) Application forms must meet the requirements set forth in 211 CMR 42.08, 211 CMR 42.09(2), 211 CMR 42.99, M.G.L. c. 175I and any other applicable Massachusetts statute or regulation.

(3) In the event that any provision of 211 CMR 42.00 is inconsistent with the provisions of 211 CMR 65.00, the provisions of 211 CMR 65.00 shall govern all matters concerning any policy form that is within the definition of long-term care insurance in 211 CMR 65.00.

65.08: Requirements for Agent Training and Marketing

(1) Each carrier shall provide appropriate training to agents about its long- term care insurance products, maintain records regarding agents who have satisfactorily completed such training and file with the commissioner lists identifying those agents who have completed the carrier's long-term care insurance training program.

(2) All long-term care insurance marketing and advertising shall conform to the provisions of 211 CMR 40.00. In addition, carriers shall establish auditable internal marketing procedures, methods for assuring compliance by agents, and prohibitions against twisting, high-pressure tactics and cold-lead advertising.

(3) All agents or persons marketing a carrier's long-term care insurance shall clearly identify which plans being offered are individual products and which are group products. When marketing group products, the agent shall clearly identify the name of the group policyholder and any conditions that the eligible person must satisfy to join and remain a member of the group.

(4) All agents marketing a carrier's long-term care insurance shall disclose to potential applicants the name of the carrier that the agent represents in the sale. The carrier's name must be disclosed on any and all printed sales or appropriate materials provided, distributed or shown to potential applicants and/or during presentations made to potential applicants in association with a sale, whether part of a presentation or not.

(5) All agents marketing a carrier's long-term care insurance policy must disclose the fact that the agent receives compensation in connection with the sale or replacement of all long-term care insurance.

(6) All agents marketing a carrier's long-term care insurance shall not misrepresent their expertise, qualifications or training to potential clients and shall not comment on the legal or tax implications of purchasing long-term care insurance to the extent that they lack the training, qualification or license to provide such advice.

(7) A carrier whose agent fails to comply with any provisions of 211 CMR 65.00, including, but not limited to, 211 CMR 65.08, will be deemed to have committed an unfair and deceptive act in the business of insurance subject to M.G.L. c. 176D.

65.09: Requirements for Disclosure

All individual and group policies of long-term care insurance must adequately disclose all policy provisions, including but not limited to the following provisions.

(1) The first page of the policy must disclose the following:

(a) If the policy does not provide coverage for care in a nursing home, a notation of the fact shall be prominently attached to the first page of the policy in not less than 18-point type or in some other manner that distinguishes it from the print otherwise appearing in the policy.

(b) The following statement: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(c) A section in boldface type highlighted on the first page of the policy shall either list all pre-existing condition exclusions or limitations or refer the individual to the section within the policy that lists all pre-existing condition exclusions or limitations.

(d) A renewability section notice shall clearly identify whether the policy is noncancelable or guaranteed renewable, and whether it is being issued on other than an individual basis (policies providing conversion privileges must specify the benefits to be provided or must state that the converted coverage shall be on the policy form then being issued by the carrier for this purpose).

(e) Qualification for Federal Income Tax Exemptions and Certain Massachusetts MassHealth (Medicaid) Exemptions.

1. All individual, group and employment-based group policies that are intended to qualify for certain federal income tax exemptions must comply with standards set forth in the federal Internal Revenue Code and related regulations.

2. All individual, group and employment-based policies issued on or after March 15, 1999 that are intended to qualify for exemptions from certain Massachusetts MassHealth (Medicaid) provisions including the financial eligibility exemption in M.G.L. c. 118E, § 25 and the liability exemption in M.G.L. c. 118E, § 33, must comply with the individual policy requirements of 211 CMR 65.05 and the minimum coverage requirements of 130 CMR 515.014. All such policies issued prior to March 15, 1999, need only comply with the minimum standards of 211 CMR 65.05, and the limitations and exclusions provisions of 211 CMR 65.06 that were effective from April 1, 1989 through September 2, 1999. The provisions of 211 CMR 65.09(1)(e)2. shall apply regardless of whether the policy is issued within or outside Massachusetts.

3. There shall be on the face of the policy or certificate, or a sticker attached to the first page of the policy or certificate, a notice that includes the following in substantially the same language and format:

FEDERAL INCOME TAX EXEMPTIONS: This policy (**IS)(IS NOT**) intended to be a federally

qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

STATE MASSHEALTH (MEDICAID) EXEMPTIONS: This policy **(IS)(IS NOT)** intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the policy's effective date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions.

Please read *Your Options for Financing Long-Term Care: A Massachusetts Guide* for important information about the federal and state exemptions. PLEASE NOTE THAT STATE AND FEDERAL LAWS ARE SUBJECT TO CHANGE AND THAT FEDERAL AND STATE EXEMPTIONS MAY NOT APPLY TO THIS POLICY AT A FUTURE DATE.

(2) Policy Language.

(a) All terms used in the policy must be fully explained so that the insured understands their relationship to the benefits covered. No misleading policy names may be used (211 CMR 65.102 includes samples of acceptable language). The policy, riders and all amendments, as well as the application, outline of coverage and other required disclosure materials distributed to any potential applicant must be presented in no less than 12-point type and must satisfy the readability standards of M.G.L. c. 175, § 2B.

(b) Riders or endorsements that provide a benefit for which a specific premium is charged must show the premium on the application, rider, or elsewhere in the policy. Any rider that reduces benefits requires a signed acceptance by the policyholder or certificateholder.

(3) Separate Disclosure Forms.

(a) No long-term care insurance policy may be delivered or issued for delivery in Massachusetts unless the potential insured receives Your Options for Financing Long-Term Care: A Massachusetts Guide, including any inserts, as prescribed by the commissioner, regarding changes to state or federal laws, no later than the first face-to-face contact between the potential insured and the agent, or in cases of direct response sales, at the time that the application or enrollment form is sent to the potential insured.

(b) No long-term care insurance policy may be delivered or issued for delivery in Massachusetts unless the applicant receives a policy illustration in a form that is substantially similar to the one set forth in 211 CMR 65.100. The carrier or its agents must deliver the policy illustration no later than the time of each policy proposal or quote. In the case of direct response sales, the carrier must deliver the form at the time that the application or enrollment form is sent to the potential insured.

(c) No long-term care insurance policy may be delivered or issued for delivery in Massachusetts unless the applicant receives an outline of coverage substantially similar to the one set forth in 211 CMR 65.101. The carrier or its agent must deliver the outline of coverage prior to the presentation of the application or enrollment form. In the case of direct response sales, the carrier must deliver the outline of coverage at the time that the application or enrollment form is sent to the potential insured. The carrier must also make an outline of coverage available at any time at the potential insured's request. The outline of coverage must be a document separate from the policy. Text that is capitalized or underscored in the standard format of the outline of coverage may be emphasized by other means that provide prominence equivalent to such capitalization or underscoring.

(4) Special Disclosure Forms.

(a) Other Than Requested. If the policy is issued on a basis other than that applied for, a disclosure statement properly describing the actual policy terms must accompany the policy when it is delivered and must contain a statement substantially similar to the following: "NOTICE: Read this disclosure statement carefully. The coverage you originally applied for has not been issued. This policy is therefore not identical to the coverage you requested, but it differs in the following respects: [list]."

(b) Required Disclosure Regarding Suitability Standards. If the carrier uses a worksheet or other marketing material to examine a potential applicant's financial situation, or uses any other marketing material that purport to provide guidance as to whether the applicant is suitable for long-term care insurance and subsequently notifies the applicant that the carrier finds the applicant to be suitable for long-term care insurance, the carrier shall provide the following disclosure notice:

"Although [the carrier] may have determined that you meet [its] internal standards of suitability, there are other considerations that might influence your decision about whether this product is appropriate for you. [The company] uses the following standards to determine suitability for its long-term care insurance policies: [list]

Please note that you should not rely upon this statement alone in making this purchase. You may want to contact a financial advisor for additional information."

(c) Required Disclosure Regarding Changes to MassHealth (Medicaid) Eligibility and Recovery Exemptions Under 130 CMR 515.014. If the carrier issued a policy that met the standards of 130 CMR 515.014 and said standards are subsequently changed, the carrier shall notify all insureds whose policies will no longer satisfy the MassHealth (Medicaid) standards and shall offer all such insureds on a guaranteed issue basis the opportunity to purchase needed benefits to meet the MassHealth (Medicaid) policy criteria. The rates for any change in benefits shall be based upon the rate characteristics for the insured at the time of policy change.

(5) Required Disclosure for Medicare-Eligible Applicants. Carriers shall provide the Guide to Health Insurance for People with Medicare and disclosure notice as required by 211 CMR 42.09(4).

65.10: Protection Against Unintentional Lapse

No individual or group long-term care insurance policy may be issued unless it complies with the following:

(1) Notice of Nonpayment of Premiums Before Lapse or Termination. No individual or group long-term care insurance policy may be issued until the carrier has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice shall not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The carrier shall notify the insured of the right to change this written designation, no less often than once every two years.

(2) Lapse or termination for nonpayment of premium. No individual or group long-term care insurance policy shall lapse or be terminated for nonpayment of premium unless the carrier, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to 211 CMR 65.10(1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of ten days after the date of mailing.

(3) Reinstatement. All individual or group long-term care insurance policies shall include a provision for reinstatement of coverage, in the event of lapse, if the carrier is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before expiration of the policy's grace period. Reinstatement shall be available to the insured if requested within five months after termination, and shall allow for the collection of past due premium, where appropriate.

65.11: Prohibition Against Post Claims Underwriting

(1) All applications and enrollment forms for individual and group long-term care insurance policies, except those that are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2) If an application or enrollment form contains a question that asks whether the applicant has had medication prescribed by a physician, then it must also ask the applicant to list the medication that has been prescribed and the reason that the medication was prescribed.

(3) Except for policies that are guaranteed issue:

(a) The following language shall be set out conspicuously near the applicant's signature block on an application:

"Caution: If your answers on this application are incorrect or untrue, [carrier] has the right to deny benefits or rescind your policy."

(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the policy, as well as the outline of coverage, at the time of delivery:

"Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers were incorrect or untrue as of the date you signed the application, the carrier has the right to deny benefits or rescind your policy subject to the [time limit on certain defenses, incontestable] section of your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the carrier at this address: [insert address]"

(c) A carrier may not deny any claims for services under a long-term care policy issued to an applicant age 80 or older unless the carrier obtained any one of the following prior to issuing the policy:

1. a report of a physical examination;

2. an assessment of functional capacity;

3. an attending physician's statement; or

4. copies of medical records.

(4) A carrier shall deliver a copy of the completed application or enrollment form to the insured no later than at the time of delivery of the policy unless the form was retained by the insured at the time of application.

(5) Every carrier selling or issuing individual or group long-term care insurance policies in Massachusetts shall maintain a record of all individual policy or group certificate rescissions, both on a state and national basis, except those that the insured voluntarily effectuated, and shall furnish this information to the commissioner upon request.

65.12: Severability

If any section or portion of a section of 211 CMR 65.00, or the applicability thereof to any person or circumstance is held invalid by any Court of competent jurisdiction, the remainder of 211 CMR 65.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.